mills river family DENTAL

Patient Medical Record

NAME: _____

Date of Birth: _____ / _____ / _____

Married? ❑ YES ❑ NO

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(W)** _____

Cell: _____ **Receive Text Alerts? Y / N**

Email: _____ @ _____

EMERGENCY CONTACT

Name: _____

Phone: _____

DENTAL INSURANCE? (Please circle one) Yes / No

Policy-Holder SSN: _____ **DOB:** __/___/___

Employer: _____

DENTAL INFORMATION

What is your problem or concern at this time?

_____

Previous Dentist: _____

Last Exam: _____

MEDICAL INFORMATION

Physician: _____

Phone: _____

Please list any MEDICATIONS currently taking:

_____

_____

Are you ALLERGIC to any medications/metals/latex?
Yes / No If YES, what? _____

Have you been HOSPITALIZED in the past 5 years?
Yes / No If YES, why? _____

_____

HAVE YOU:

Ever taken Fosamax, Boniva, Actonel or any cancer medications with bisphosphonates?	❑ Y ❑ N
Ever taken Phen-Fen or Redux?	❑ Y ❑ N
Taken Viagra, Revatio, Cialis or Levitra in the past 24 hours?	❑ Y ❑ N
Do you use tobacco?	❑ Y ❑ N
Do you use controlled substances?	❑ Y ❑ N
Had a persistent cough for more than 3 weeks?	❑ Y ❑ N

FOR WOMEN

Pregnant?	❑ Y ❑ N
Nursing?	❑ Y ❑ N
Use oral contraceptives?	❑ Y ❑ N

DO YOU HAVE OR HAVE YOU EVER HAD:

❑ **YES**	❑ **NO**	Epilepsy/Convulsions/Fainting
❑ **YES**	❑ **NO**	Leukemia
❑ **YES**	❑ **NO**	Diabetes
❑ **YES**	❑ **NO**	Kidney Disease
❑ **YES**	❑ **NO**	AIDS or HIV Infection
❑ **YES**	❑ **NO**	Sexually Trasnsmitted Disease
❑ **YES**	❑ **NO**	Thyroid Problems
❑ **YES**	❑ **NO**	Anemia
❑ **YES**	❑ **NO**	Cancer: _____
❑ **YES**	❑ **NO**	Radiation Therapy
❑ **YES**	❑ **NO**	Chemotherapy
❑ **YES**	❑ **NO**	Arthritis
❑ **YES**	❑ **NO**	Joint Replacement
❑ **YES**	❑ **NO**	Premedication
❑ **YES**	❑ **NO**	Hepatitis
❑ **YES**	❑ **NO**	Rheumatic Fever
❑ **YES**	❑ **NO**	Stomach Troubles/Ulcers
❑ **YES**	❑ **NO**	Hay Fever/Allergies
❑ **YES**	❑ **NO**	Tuberculosis
❑ **YES**	❑ **NO**	Glaucoma
❑ **YES**	❑ **NO**	Liver Disease
❑ **YES**	❑ **NO**	High Blood Pressure
❑ **YES**	❑ **NO**	Low Blood Pressure
❑ **YES**	❑ **NO**	Stroke
❑ **YES**	❑ **NO**	Heart Attack
❑ **YES**	❑ **NO**	Heart Disease/Murmur
❑ **YES**	❑ **NO**	Mitral Valve Prolapse
❑ **YES**	❑ **NO**	Pacemaker
❑ **YES**	❑ **NO**	Angina (Chest Pains)
❑ **YES**	❑ **NO**	Emphysema
❑ **YES**	❑ **NO**	Asthma
❑ **YES**	❑ **NO**	Respiratory Problems
❑ **YES**	❑ **NO**	High Cholesterol
❑ **YES**	❑ **NO**	Osteoporosis

Is there anything else we should know about your health that is not covered?

_____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. If I am here on an emergency basis, I understand that this examination will address only my immediate problem or emergency, and should not be confirmed as a complete examination with resulting treatment.

PATIENT'S or GUARDIAN'S SIGNATURE and DATE

_____